CHRONOLOGICAL RECORD OF MEDICAL CARE

# Smallpox Vaccination Clinical/Sick-call Follow up Note

4903

1. Today's Date ( M M / D D / Y Y Y Y )

2a. Day 0 = Smallpox Vaccination Date

2b. Days post vax

QA number

3. Vital Signs Temp . Pulse Resp BP /

4. Chief Complaint (Default = routine check)

5. Was there a bandage on the vaccination site? ○ Yes ○ No

5a. IF YES: How many days did patient use a bandage?

5b. Did patient see the vaccination site every day or two? ○ Yes ○ No

6a. Vaccination site appearance today (Check all that apply)

- ☐ local redness
- ☐ scab or crust
- ☐ bump
- ☐ local itching
- ☐ reddish blister
- ☐ local rash
- ☐ whitish blister
- ☐ nothing

6b. Patient recall of appearance since vaccination (Check all that apply)

- ☐ local redness
- ☐ scab or crust
- ☐ bump
- ☐ local itching
- ☐ reddish blister
- ☐ local rash
- ☐ whitish blister
- ☐ nothing seen
- ☐ patient did not remember/observe

7. Check anything else experienced after the smallpox vaccination (Check all that apply)

- ☐ headache
- ☐ muscle aches
- ☐ body rash
- ☐ feeling lousy
- ☐ itchy all over
- ☐ swollen lymph nodes
- ☐ eye infection
- ☐ bandage reaction
- ☐ fever (temp in box)
- ☐ other (describe in box)

8. Any problems following vaccination? (Check all that apply)

- ☐ Restricted activity — How many days?
- ☐ Limited duty — How many days?
- ☐ Missed work — How many days?
- ☐ Took medication (list in box) — How many days?
- ☐ Visited clinic or emergency room
- ☐ Hospitalized
- ☐ Other (describe in box)

9. Vaccination Site measurements (if indicated)

Erythema length (mm) X width

Vesicle length (mm) X width

Note any other reactions, problems or medications following vaccination:

10. Does the patient believe anyone might have become ill as a result of the vaccination? ○ Yes ○ No ○ Unsure

If YES or UNSURE, describe in box (or on continuation page)

**11. Assessment and Plan (check all that apply):**

- ☐ Fully Immunized ("major reaction," "take")
- ☐ Equivocal response
- ☐ No response
- ☐ Re-vaccination indicated
- ☐ Follow-up for events described
- ☐ Medication prescribed (list)
- ☐ No further follow up planned
- ☐ Consultation (Allergy/Immunology/Dermatology/other_____)
- ☐ Other action (describe in box) Report to VAERS if warranted.

**11a. Other assessment/plan related to evaluation**

**12. Duty limitations**

- ☐ Full duty
- ☐ No direct patient care
- ☐ Quarters for _____ days
- ☐ Urgent/Emergent referral
- ☐ Routine referral

**Provider Signature and Printed Name/Stamp:**

Patient's Identification (May use mechanical imprint)

Last Name

First Name MI

Social Security Number - -

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPART./SER